DEPARTMENT OF HUMAN SERVICES POLICY ISSUANCE

Bismarck, ND

PI-11-24

To: Regional DD Program Administrators,
Licensed DD Service Providers, Barb Murry,
Developmental Center, Linda Babcock

From: Division of Developmental Disabilities

Date: December 22, 2011

Subject: Revised Program Absences Policy

The following policy is effective January 1, 2012, and replaces the former Program Absences Policy PI-10-11effective July 1, 2010.

This is to clarify the differences for ICF/ID (state fiscal year) vs. other programs which are based on the providers fiscal year, revise types of services applicable to absences, provide examples, and combine DDD-PI-066 into this policy rather than maintain it as a separate policy/attachment.

The CMS Manual Part 1guidence (see The Provider Reimbursement Manual Part 1, Chapter 21, Section 2105.3) require that payments cannot be made for services not provided or that are duplicative of other services provided through the Medicaid program. In order to maintain continuity of services for individuals, the following exceptions are available as provided by NDAC 75-04-05-10.3.g.(1) for reimbursement for 'bed-hold' days in which individuals are absent from the service setting. No other exceptions are available.

The 30 days of allowable absences each year is applicable to the **client** not the provider. (i.e. the **client** is allowed 30 days of absences each year. If a client changes provider's mid-year, the absences will be pro-rated. In the event the client has used more than the pro-rated amount while enrolled with the initial provider, the client absences will be pro-rated based on the absences already accrued to determine the absences the client has remaining when enrolled with the new provider.)

Type of Service: Intermittent (ISLA, FCO III) – Calendar Year

Exceptions Allowed: Two options are available. Census records must identify which option is being utilized for an individual.

1. Unplanned Absences / Shared Staffing - 30 days. An ***absence*** is hospitalization or absence from the service setting to the extent the individual is not available to receive direct service from the provider, or is receiving from another source, support that would normally be the responsibility of the provider. ***"Not available"*** means a day in which the individual does not stay

in their own residence overnight. If staff are called and respond to assist the individual due to an emergency at their actual location on a day which otherwise would be an absence, that day will not be counted as an absence. Any absences in excess of 30 days are not billable.

2. Planned Absences - None. If an individual routinely is expected to be out of the service setting for periods of time, the authorization may be developed as if the individual will not be routinely absent from the service setting. The increased daily rate will offset basing rates on only actual service and excluding payment for absence days not included in the rate determination. The authorization should identify this procedure and the additional hours added for this purpose. If this option is utilized, no absences are billed. For example:

> An individual is authorized for 50 hours of direct service per month. The individual, however, spends 2 days a week away from the service setting with family. The authorization has previously been adjusted down to account for this time. The individual receives services 21.5 days per month (5 X 4.3) at 2.3 hours per day (50 -;- 21.5). The authorization is then written for 30 days per month at 2.3 hours per day, a total of 69 hours. With this option only actual days of service are billable. Any absence day is non-billable.

A change in options can only be made at the time an initial authorization for service is developed or at the expiration of an existing authorization. When changing options, the allowed absences under Option 1 will be prorated for the calendar year according to the amount of time Option 1 is in effect during that calendar year.

Type of Service: **SLA - Calendar Year**

Exceptions Allowed: Limited to 30 days for hospitalization or absence from the service setting to the extent the individual is not available to receive direct service from the provider, or is receiving from another source, support that would normally be the responsibility of the provider. *"Not available"* means a day in which the individual does not stay in their own residence overnight. If staff are called and respond to assist the individual due to an emergency at their actual location on a day which otherwise would be an absence, that day will not be counted as an absence.

Type of Service: **Facility based residential waiver (Congregate Care, TCLF, MSLA, Specialized Placement – Calendar year)**

Exceptions Allowed: Limited to 30 days total per **calendar year** for all days in which the individual is not in overnight residence in the facility as defined in examples on pages 4, 5 and 6.

Type of Service: **Non-daily rates (Day Supports, In-Home Supports, FCO, Extended Services, Self Directed Services, Extended Home Health, Infant Development, Parenting Supports, Intervention Coordination)**

Exceptions Allowed: None. Billing allowed only for actual service units delivered.

Type of Service: **ICF/ID - Calendar year**

Exceptions Allowed: Limited to 30 days total per calendar year for all days in which the individual is not in overnight residence in the facility as defined in examples on pages 4, 5, and 6, and up to 15 days per hospitalization are allowed.

The calendar year will be used for counting ICF absences. Provider census data needs to identify any absences as Therapeutic Leave or Hospitalization (Therapeutic leave being any absence except for hospitalization. Billing codes below must be used for ICF/ID claims.

The following billing codes must be used for ICF/ID claims:

	ICF/ID Billing Codes			
	Adult ICF/ID	ICF Phy Hdc	ICF Child	Days Allowed
In-house	110	120	160	
Therapeutic	180	183	169	30 per calendar year
Hospital	182	185	189	15 per occurrence

Therapeutic Leave cannot be applied to Hospitalization Leave and Hospitalization Leave cannot be used for Therapeutic Leave.

Implementation Provisions

1. Hospitalization does not include the ND State Hospital or other institutional placement. An individual will not be enrolled in community services during admission to the ND State Hospital, ND Developmental Center, or other institution (nursing facility, swing bed, etc.).
2. Providers must maintain census records which identify absent days and the reason (hospitalization, out-of-town/state, etc.).
3. An absence does not include days in which the individual is out of the service setting but is continuing to receive direct service staffing by the provider agency in the off-site location. However, absences are counted during a period of hospitalization regardless of support a provider may be giving to an individual.
4. The number of absences allowed for residential programs, except for ICF/ID, is based on the time enrolled in the program during the calendar year. The number of absences allowed for ICF/ID is based on the time

enrolled in the ICF/ID during the calendar year. This includes new admissions to the providership and internal transfers between residential programs.

5. A provider may elect to not bill for excess absence days for CC, MSLA, TCLF, Specialized Placement, ICF/ID, and SLA. Non-billed days will not be counted as an absence on audit. Census records must identify those absence days that are non-billed.

The following provisions will be used in determining what constitutes an absence for residential census purposes:

POLICY: An individual present in a group facility at midnight will be considered as present for the day just ended.

Intent: To provide a consistent guideline in determining when an individual should be considered as present for determination of 95% occupancy rules and the 30 day absence allowance. It is assumed the provider has had responsibility for direct care and programming for the individual for the day in which the attendance is recorded. A token return to the facility to meet a midnight "bed count" and then leaves is not to be considered present as it is an attempt to circumvent the intent of the policy.

Example:
An individual leaves at 5:30 p.m. on January 20 to spend a weekend with family. The individual returns to the residential facility at 8:30 p.m. on January 23. The person would be considered present on January 19, absent on January 20, 21, and 22 and present on the 23rd.

Example:
On January 25, Helga and a friend leave in early evening for a dinner out and late movie. He returns at 12:45 a.m. on the 26th. Helga is considered present for the 25th. Although he was not present at midnight, he obviously was not residing elsewhere at the time and remained in the sphere of the provider's direct responsibility for care and programming.

POLICY: An individual will be considered present on the day of admission to a program, but not the day of discharge.

Intent: To provide a method of determining occupancy and for payment that is consistent with other Department of Human Service Programs. For the purposes of this policy, a change in screening level from an ICF/ID to Swing Bed facility is considered a discharge from the ICF/ID even though the ICF/ID provider is not discharging the individual from the agency.

Example: On the afternoon of February 2, Helga is admitted to a hospital. On February 5th in the afternoon, she is transferred to a Swing Bed facility for recovery and returns to the ICF/ID group home on the morning of February 15. The ICF/ID can count Helga as present through February **1;** for 95%occupancy determination purposes and is eligible for payment through February 4 (February 2 – 4 may be billed as hospitalization days – per policy above). A Level of Care Determination change would be completed discharging her from the ICF/ID on the 5th and admitting her to the Swing Bed on the 5th. The ICF/ID facility would be eligible for payment for the 15th and the Swing Bed facility would not.

POLICY: Occupancy and eligibility for payment will include the date of death of an individual (assuming the individual is not screened to another level of care at the time of

death).

POLICY: 30 absence days is based on the client each year, and not on the provider.

Example (transfer between providers): Helga is moving from Provider 1 ICF/ID to Provider 2 ICF/ID on July 1st. ICF/ID follows the calendar year of January to December regardless of the provider fiscal year. Each provider will have had Helga in their ICF/ID program for six months, which would allow each 15 days of absences. If Helga had used 17 absences while in Provider 1's ICF/ID program, Provider 2 will only be allowed 13 absences even though the prorated amount is 15 absences.

Provider 1 ICF/ID – Helga is with Provider 1 from January 1st, and discharged on July 1st. If you take 30 allowable absences divided by 12 months, then multiply the sum by 6 months for the time spent in Provider 1 ICF/ID the total will be 15. ((30 days / 12 months) * 6 months) = 15 days

Provider 2 ICF/ID – Helga will be with Provider 2 from July 1st to December 31st. If you take 30 allowable absences divided by 12 months, then multiply the sum by 6 months for the time spent in Provider 2 ICF/ID the total will be 15. ((30 days / 12 months) * 6 months) = 15 days

If Helga used 17 absences between January 1st and July 1st at Provider 1 ICF/ID, then Provider 2 ICF/ID can only use 13 (15 days allowed at Provider 1 ICF/ID plus 15 days allowed at Provider 2 ICF/ID less 17 days already used) absences in order to make sure Helga (the client) does not exceed her 30 allowable absences maximum.

Example (transfer between waiver group home and providers): Helga is moving from Provider 1 MSLA to Provider 2 ISLA – Option 1 on September 1st. Provider 1's fiscal year is October to September, while Provider 2's fiscal year is July to June. However, the absences policy states all absences (regardless of program) will be tracked on a calendar year. Provider 1 would be allowed 20 absences for Helga, while Provider 2 will be allowed 10 absences for Helga. If Helga had used her 22 absences prior to moving to Provider 2's ISLA – Option 1, Provider 2 will only be allowed 8 absences from September 1st to December 31st.

Provider 1 MSLA – Helga is with Provider 1 at the beginning of the calendar year (January 1st) and discharged on September 1st. If you take 30 allowable absences divided by 12 months, then multiply the sum by 8 months for the time spent in Provider 1 MSLA the total will be 20. ((30 days / 12 months) * 8 months) = 20 days

Provider 2 ISLA – Option 1 – Helga will be with Provider 2 from September 1st through December 31st. If you take 30 allowable absences divided by 12 months, then multiply the sum by 4 months for the time spent in Provider 2 ISLA – Option 1 the total will be 10. ((30 days / 12 months) * 4 months) = 10 days

If Helga used 22 absences between January 1st and September 1st at Provider 1 MSLA, then Provider 2 ISLA – Option 1 can only use 8 (22 allowed absences at Provider 1 MSLA plus 10 allowed absences at Provider 2 ISLA – Option 1 less 30 absences used at Provider 1 MSLA) absences in order to make sure Helga (the client) does not exceed her 30 allowable absences maximum.

Example (transfer within provider): Helga is moving from Provider 1 ICF/ID to Provider 1 TCLF on September 1st. Provider 1's fiscal year is October to September, while all absences are

tracked on the calendar year (January to December). Provider 1 ICF/ID would be allowed 20 absences for Helga, while Provider 1 TCLF would be allowed 10 absences for Helga. If Helga used 25 absences prior to changing from the ICF/ID to the TCLF, then the TCLF would only be allowed 5 absences.

Provider 1 ICF/ID – Helga is with Provider 1 ICF/ID beginning January 1st, and discharged on September 1st. If you take 30 allowable absences divided by 12 months, then multiply the sum by 8 months for the time spent in Provider 1 ICF/ID the total will be 20. ((30 days / 12 months) * 8 months) = 20 days

Provider 1 TCLF – Helga will be with Provider 1 TCLF from September 1st to December 31st. If you take 30 allowable absences divided by 12 months, then multiply the sum by 4 month for the time spent in Provider 1 TCLF the total will be 10 absences. ((30 days / 12 months) * 4 months) = 10 days

If Helga used 25 absences between January 1st and September 1st at Provider 1 ICF/ID, then Provider 1 TCLF can only use 5 (20 days allowed at Provider 1 ICF/ID plus 10 days allowed at Provider 1 TCLF less 25 absences used at Provider 1 ICF/ID) absences in order to make sure Helga (the client) does not exceed her 30 allowable absences maximum in one fiscal year.